**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**
**MEDICAID PURCHASING ADMINISTRATION**
**Olympia, Washington**

| | | |
|---|---|---|
| **To:** | Outpatient Hospitals<br>Managed Care Organizations | **Memorandum No: 10-42**<br>**Issued:** June 30, 2010 |
| **From:** | Douglas Porter, Assistant Secretary<br>Medicaid Purchasing Administration (MPA) | **For information, contact:**<br>1-800-562-3022, option 2, or go to:<br>http://hrsa.dshs.wa.gov/contact/default.aspx |

**Subject: Outpatient Hospital Services: Fee Schedule Updates and Policy Changes**

**Effective for dates of service on and after July 1, 2010**, the Department of Social & Health Services (the Department) will update the:

- *Outpatient Hospitals and Outpatient Prospective Payment System (OPPS) Fee Schedule* with the updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2010 Relative Value Units (RVUs), Current Procedural Terminology (CPT®) codes, and Healthcare Common Procedure Coding System (HCPCS) codes; and
- *Outpatient Hospital Services Billing Instructions* with the policy changes outlined in this memo.

## Overview

All policies previously published remain the same unless specifically identified as changed in this memo.

## Fee Schedule Updates and Maximum Allowable Fee Adjustments

**Effective for dates of service on and after July 1, 2010,** the Department will update the *Outpatient Hospitals and OPPS Fee Schedule* with the updated:

- MPFSDB Year 2010 RVUs; and
- CPT and HCPCS codes.

The Department will adjust the maximum allowable fees to reflect these new rates.

Bill the Department your usual and customary charge.

## Viewing Changes to the Fee Schedule

To view the July 1, 2010, fee schedule changes, go to the Department/Medicaid Purchasing Administration (MPA) website online at: http://hrsa.dshs.wa.gov/RBRVS/Index.html.

## Outpatient Service Payment Changes

**Effective for dates of service on and after July 1, 2010,** the Department will change the payment method applied to the following codes, for situations where the Ambulatory Payment Classification (APC) payment method does not apply:

| Procedure Code | Coverage Indicator | Alternate Payment Method |
|---|---|---|
| 75960 | 1 | Max Fee |
| 86336 | 1 | Max Fee |
| 88380 | 1 | Max Fee |

**Note:** Due to its licensing agreement with the American Medical Association (AMA) regarding the use of CPT codes and descriptions, the Department publishes only the official brief descriptions for all codes. Please refer to your current CPT book for full descriptions.

## Added Procedure Codes

**Effective for dates of service on and after July 1, 2010**, the Department will update the *Outpatient Hospital and OPPS Fee Schedule* for procedures performed in an outpatient hospital setting. Procedures with a value in the Alternate Payment Method column may be paid using that method if an APC payment is not applicable. Where no method is listed, the Ratio of Cost-to-Charges (RCC) method may be used if APC payment is not applicable.

| Auth | Procedure Code | Short Description | Coverage Indicator | Maximum Units | Alternate Payment Method |
|---|---|---|---|---|---|
| | 90670 | Pneumococcal vacc, 13 val im | 1 | 1 | Max Fee |
| | C9258 | Telavancin injection | 1 | UR | |
| PA | C9259 | Pralatrexate injection | 1 | UR | |
| | C9260 | Ofatumumab injection | 1 | UR | |
| PA** | C9261 | Ustekinumab injection | 1 | UR | |
| | C9262 | Fludarabine phosphate, oral | 1 | UR | |
| | C9263 | Ecallantide injection | 1 | UR | |
| | G0432 | A EIA HIV-1/HIV-2 screen | 0 | NA | |
| | G0433 | ELISA HIV-1/HIV-2 screen | 0 | NA | |

**see below for coverage criteria

| Auth | Procedure Code | Short Description | Coverage Indicator | Maximum Units | Alternate Payment Method |
|---|---|---|---|---|---|
| | G0435 | Oral HIV-1/HIV-2 screen | 0 | NA | |
| | G9147 | Outpt IV insulin tx any mea | 0 | NA | |

**Legend**
A = Covered, ambulatory payment classification (APC)-paid hospitals (OPPS) only.
B = Covered, non-OPPS and critical access hospitals (CAH) only.
L = Use of this procedure code may have certain limitations or restrictions (e.g., ages, authorization requirements, diagnosis, or facilities). Please see program specific publications for details prior to providing this service.
1 = Covered, all hospitals paid in accordance with each hospital's specific payment methodology.
PA = Prior Authorization.
UR = Under Review
BR = By Report

## Noncovered Procedure Code on Hospital Claims

**Effective for dates of service on and after July 1, 2010,** the Department **will not cover** CPT code 90657 when billed on a hospital claim:

## Prior Authorization Changes

**Effective for dates of service on and after July 1, 2010,** the Department will no longer require prior authorization (PA) for the following codes:

| Auth | Procedure Code | Coverage Indicator | Alternate Payment Method |
|---|---|---|---|
| No | 31825 | 1 | |
| No | 31830 | 1 | |

**Effective for dates of service on and after July 1, 2010,** the Department will require PA for the following codes:

| Auth | Procedure Code | Short Description | Coverage Indicator | Maximum Units |
|---|---|---|---|---|
| PA | G0173 | Linear acc stereo radsur com | 1 | 1 |
| PA | G0251 | Linear acc based stero radio | 1 | 1 |

## Prior Authorization Criteria

**Stelara™ (*Ustekinumab*)**
**(HCPCS code C9261)**

PA is required. Include the following information in PA requests to the Department:

- Stelara™ is being used to treat moderate to severe plaque psoriasis (include diagnosis confirmation date); and

- All of the following:

  - ✓ Stelara™ is prescribed by a dermatologist;
  - ✓ Client is 18 years of age or older;
  - ✓ Client has tried and failed course of Enbrel® or Humira® (include dates and doses of trial(s); and
  - ✓ Dose does not exceed a maximum dose of 90mg every 12 weeks after initial induction dose given, 90mg for 4 weeks.

**Note:** Verification that client meets criteria must be documented on the request form* **and** supported by the clinical record.

*The Department will publish Stelara™ request form as soon as possible.

## Two Episodes of Care on a Single Date of Service

When billing two separate claims for a single date of service, providers must indicate that the second visit is a distinctly separate episode of care. The diagnosis and procedure codes must also indicate that the second visit is a distinctly separate episode of care.

## How Can I Get the Department/MPA Provider Documents?

To download and print the Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).